



100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

HB4114

by Rep. Peter Breen

SYNOPSIS AS INTRODUCED:

See Index

Creates the No Taxpayer Funding for Abortion Act. Provides that neither the State nor any of its subdivisions may authorize the use of, appropriate, or expend funds to pay for an abortion or to cover any part of the costs of a health plan that includes coverage of abortion or to provide or refer for an abortion, unless a woman who suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death if an abortion is not performed. Amends the State Employees Group Insurance Act of 1971 and the Illinois Public Aid Code. Excludes from the programs of health benefits and services authorized under those Acts coverage for elective abortions as provided in the No Taxpayer Funding for Abortion Act. Prohibits a physician who has been found guilty of performing an abortion procedure in a willful and wanton manner upon a woman who was not pregnant when the abortion procedure was performed from participating in the State's Medical Assistance Program. Provides that the Department of Healthcare and Family Services shall require a written statement, including the required opinion of a physician, to accompany a claim for reimbursement for abortions or induced miscarriages or premature births. Makes other changes. Amends the Problem Pregnancy Health Services and Care Act. Permits the Department of Human Services to make grants to nonprofit agencies and organizations that do not use those grants to refer or counsel for, or perform, abortions. Contains provisions regarding applicability and preempts home rule. Effective on the earlier of the effective date of Public Act 100-538 or June 1, 2018.

LRB100 15067 KTG 29910 b

FISCAL NOTE ACT
MAY APPLY

HOME RULE NOTE
ACT MAY APPLY

A BILL FOR

1 AN ACT concerning abortion.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 1. Short title. This Act may be cited as the No
5 Taxpayer Funding for Abortion Act.

6 Section 5. Public policy. It is the public policy of this
7 State that the General Assembly of the State of Illinois does
8 solemnly declare and find in reaffirmation of the longstanding
9 policy of this State that the unborn child is a human being
10 from the time of conception and has a right to life and, to the
11 extent consistent with the United States Constitution,
12 Illinois law should be interpreted to recognize that right to
13 life and to protect unborn life.

14 The General Assembly further declares and finds that, while
15 the people of Illinois hold a variety of positions on the issue
16 of abortion, they generally oppose the use of tax dollars to
17 pay for elective abortions and support the federal Hyde
18 Amendment, named after the late Henry J. Hyde, whose memory is
19 revered and service celebrated as a Congressman from the great
20 State of Illinois. This Act honors the strong beliefs of the
21 people of Illinois by prohibiting the taxpayer funding of
22 abortion in this State.

1 Section 10. Use of funds to pay for abortions prohibited;
2 exceptions. Notwithstanding any other provision of law,
3 neither the State nor any of its subdivisions may authorize the
4 use of, appropriate, or expend any funds to pay for any
5 abortion or to cover any part of the costs of any health plan
6 that includes coverage of abortion or to provide or refer for
7 any abortion, except in the case where a woman suffers from a
8 physical disorder, physical injury, or physical illness that
9 would, as certified by a physician, place the woman in danger
10 of death unless an abortion is performed, including a
11 life-endangering physical condition caused by or arising from
12 the pregnancy itself, or in such other circumstances as
13 required by federal law.

14 Section 900. The State Employees Group Insurance Act of
15 1971 is amended by changing Sections 6 and 6.1 as follows:

16 (5 ILCS 375/6) (from Ch. 127, par. 526)

17 (Text of Section before amendment by P.A. 100-538)

18 Sec. 6. Program of health benefits.

19 (a) The program of health benefits shall provide for
20 protection against the financial costs of health care expenses
21 incurred in and out of hospital including basic
22 hospital-surgical-medical coverages. The program may include,
23 but shall not be limited to, such supplemental coverages as
24 out-patient diagnostic X-ray and laboratory expenses,

1 prescription drugs, dental services, hearing evaluations,
2 hearing aids, the dispensing and fitting of hearing aids, and
3 similar group benefits as are now or may become available.
4 However, nothing in this Act shall be construed to permit, on
5 or after July 1, 1980, the non-contributory portion of any such
6 program to include the expenses of obtaining an abortion,
7 induced miscarriage or induced premature birth unless, in the
8 opinion of a physician, such procedures are necessary for the
9 preservation of the life of the woman seeking such treatment,
10 or except an induced premature birth intended to produce a live
11 viable child and such procedure is necessary for the health of
12 the mother or the unborn child. The program may also include
13 coverage for those who rely on treatment by prayer or spiritual
14 means alone for healing in accordance with the tenets and
15 practice of a recognized religious denomination.

16 The program of health benefits shall be designed by the
17 Director (1) to provide a reasonable relationship between the
18 benefits to be included and the expected distribution of
19 expenses of each such type to be incurred by the covered
20 members and dependents, (2) to specify, as covered benefits and
21 as optional benefits, the medical services of practitioners in
22 all categories licensed under the Medical Practice Act of 1987,
23 (3) to include reasonable controls, which may include
24 deductible and co-insurance provisions, applicable to some or
25 all of the benefits, or a coordination of benefits provision,
26 to prevent or minimize unnecessary utilization of the various

1 hospital, surgical and medical expenses to be provided and to
2 provide reasonable assurance of stability of the program, and
3 (4) to provide benefits to the extent possible to members
4 throughout the State, wherever located, on an equitable basis.
5 Notwithstanding any other provision of this Section or Act, for
6 all members or dependents who are eligible for benefits under
7 Social Security or the Railroad Retirement system or who had
8 sufficient Medicare-covered government employment, the
9 Department shall reduce benefits which would otherwise be paid
10 by Medicare, by the amount of benefits for which the member or
11 dependents are eligible under Medicare, except that such
12 reduction in benefits shall apply only to those members or
13 dependents who (1) first become eligible for such medicare
14 coverage on or after the effective date of this amendatory Act
15 of 1992; or (2) are Medicare-eligible members or dependents of
16 a local government unit which began participation in the
17 program on or after July 1, 1992; or (3) remain eligible for
18 but no longer receive Medicare coverage which they had been
19 receiving on or after the effective date of this amendatory Act
20 of 1992.

21 Notwithstanding any other provisions of this Act, where a
22 covered member or dependents are eligible for benefits under
23 the federal Medicare health insurance program (Title XVIII of
24 the Social Security Act as added by Public Law 89-97, 89th
25 Congress), benefits paid under the State of Illinois program or
26 plan will be reduced by the amount of benefits paid by

1 Medicare. For members or dependents who are eligible for
2 benefits under Social Security or the Railroad Retirement
3 system or who had sufficient Medicare-covered government
4 employment, benefits shall be reduced by the amount for which
5 the member or dependent is eligible under Medicare, except that
6 such reduction in benefits shall apply only to those members or
7 dependents who (1) first become eligible for such Medicare
8 coverage on or after the effective date of this amendatory Act
9 of 1992; or (2) are Medicare-eligible members or dependents of
10 a local government unit which began participation in the
11 program on or after July 1, 1992; or (3) remain eligible for,
12 but no longer receive Medicare coverage which they had been
13 receiving on or after the effective date of this amendatory Act
14 of 1992. Premiums may be adjusted, where applicable, to an
15 amount deemed by the Director to be reasonably consistent with
16 any reduction of benefits.

17 (b) A member, not otherwise covered by this Act, who has
18 retired as a participating member under Article 2 of the
19 Illinois Pension Code but is ineligible for the retirement
20 annuity under Section 2-119 of the Illinois Pension Code, shall
21 pay the premiums for coverage, not exceeding the amount paid by
22 the State for the non-contributory coverage for other members,
23 under the group health benefits program under this Act. The
24 Director shall determine the premiums to be paid by a member
25 under this subsection (b).

26 (Source: P.A. 93-47, eff. 7-1-03.)

1 (Text of Section after amendment by P.A. 100-538)

2 Sec. 6. Program of health benefits.

3 (a) The program of health benefits shall provide for
4 protection against the financial costs of health care expenses
5 incurred in and out of hospital including basic
6 hospital-surgical-medical coverages. The program may include,
7 but shall not be limited to, such supplemental coverages as
8 out-patient diagnostic X-ray and laboratory expenses,
9 prescription drugs, dental services, hearing evaluations,
10 hearing aids, the dispensing and fitting of hearing aids, and
11 similar group benefits as are now or may become available,
12 except as provided in the No Taxpayer Funding for Abortion Act.
13 The program may also include coverage for those who rely on
14 treatment by prayer or spiritual means alone for healing in
15 accordance with the tenets and practice of a recognized
16 religious denomination.

17 The program of health benefits shall be designed by the
18 Director (1) to provide a reasonable relationship between the
19 benefits to be included and the expected distribution of
20 expenses of each such type to be incurred by the covered
21 members and dependents, (2) to specify, as covered benefits and
22 as optional benefits, the medical services of practitioners in
23 all categories licensed under the Medical Practice Act of 1987,
24 (3) to include reasonable controls, which may include
25 deductible and co-insurance provisions, applicable to some or

1 all of the benefits, or a coordination of benefits provision,
2 to prevent or minimize unnecessary utilization of the various
3 hospital, surgical and medical expenses to be provided and to
4 provide reasonable assurance of stability of the program, and
5 (4) to provide benefits to the extent possible to members
6 throughout the State, wherever located, on an equitable basis.
7 Notwithstanding any other provision of this Section or Act, for
8 all members or dependents who are eligible for benefits under
9 Social Security or the Railroad Retirement system or who had
10 sufficient Medicare-covered government employment, the
11 Department shall reduce benefits which would otherwise be paid
12 by Medicare, by the amount of benefits for which the member or
13 dependents are eligible under Medicare, except that such
14 reduction in benefits shall apply only to those members or
15 dependents who (1) first become eligible for such medicare
16 coverage on or after the effective date of this amendatory Act
17 of 1992; or (2) are Medicare-eligible members or dependents of
18 a local government unit which began participation in the
19 program on or after July 1, 1992; or (3) remain eligible for
20 but no longer receive Medicare coverage which they had been
21 receiving on or after the effective date of this amendatory Act
22 of 1992.

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24 covered member or dependents are eligible for benefits under
25 the federal Medicare health insurance program (Title XVIII of
26 the Social Security Act as added by Public Law 89-97, 89th

1 Congress), benefits paid under the State of Illinois program or
2 plan will be reduced by the amount of benefits paid by
3 Medicare. For members or dependents who are eligible for
4 benefits under Social Security or the Railroad Retirement
5 system or who had sufficient Medicare-covered government
6 employment, benefits shall be reduced by the amount for which
7 the member or dependent is eligible under Medicare, except that
8 such reduction in benefits shall apply only to those members or
9 dependents who (1) first become eligible for such Medicare
10 coverage on or after the effective date of this amendatory Act
11 of 1992; or (2) are Medicare-eligible members or dependents of
12 a local government unit which began participation in the
13 program on or after July 1, 1992; or (3) remain eligible for,
14 but no longer receive Medicare coverage which they had been
15 receiving on or after the effective date of this amendatory Act
16 of 1992. Premiums may be adjusted, where applicable, to an
17 amount deemed by the Director to be reasonably consistent with
18 any reduction of benefits.

19 (b) A member, not otherwise covered by this Act, who has
20 retired as a participating member under Article 2 of the
21 Illinois Pension Code but is ineligible for the retirement
22 annuity under Section 2-119 of the Illinois Pension Code, shall
23 pay the premiums for coverage, not exceeding the amount paid by
24 the State for the non-contributory coverage for other members,
25 under the group health benefits program under this Act. The
26 Director shall determine the premiums to be paid by a member

1 under this subsection (b).

2 (Source: P.A. 100-538, eff. 1-1-18.)

3 (5 ILCS 375/6.1) (from Ch. 127, par. 526.1)

4 (Text of Section before amendment by P.A. 100-538)

5 Sec. 6.1. The program of health benefits may offer as an
6 alternative, available on an optional basis, coverage through
7 health maintenance organizations. That part of the premium for
8 such coverage which is in excess of the amount which would
9 otherwise be paid by the State for the program of health
10 benefits shall be paid by the member who elects such
11 alternative coverage and shall be collected as provided for
12 premiums for other optional coverages.

13 However, nothing in this Act shall be construed to permit,
14 after the effective date of this amendatory Act of 1983, the
15 noncontributory portion of any such program to include the
16 expenses of obtaining an abortion, induced miscarriage or
17 induced premature birth unless, in the opinion of a physician,
18 such procedures are necessary for the preservation of the life
19 of the woman seeking such treatment, or except an induced
20 premature birth intended to produce a live viable child and
21 such procedure is necessary for the health of the mother or her
22 unborn child.

23 (Source: P.A. 85-848.)

24 (Text of Section after amendment by P.A. 100-538)

1 Sec. 6.1. The program of health benefits may offer as an
2 alternative, available on an optional basis, coverage through
3 health maintenance organizations. That part of the premium for
4 such coverage which is in excess of the amount which would
5 otherwise be paid by the State for the program of health
6 benefits shall be paid by the member who elects such
7 alternative coverage and shall be collected as provided for
8 premiums for other optional coverages, except as provided in
9 the No Taxpayer Funding for Abortion Act.

10 (Source: P.A. 100-538, eff. 1-1-18.)

11 Section 905. The Illinois Public Aid Code is amended by
12 changing Sections 5-5, 5-8, 5-9, and 6-1 as follows:

13 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

14 (Text of Section before amendment by P.A. 100-538)

15 Sec. 5-5. Medical services. The Illinois Department, by
16 rule, shall determine the quantity and quality of and the rate
17 of reimbursement for the medical assistance for which payment
18 will be authorized, and the medical services to be provided,
19 which may include all or part of the following: (1) inpatient
20 hospital services; (2) outpatient hospital services; (3) other
21 laboratory and X-ray services; (4) skilled nursing home
22 services; (5) physicians' services whether furnished in the
23 office, the patient's home, a hospital, a skilled nursing home,
24 or elsewhere; (6) medical care, or any other type of remedial

1 care furnished by licensed practitioners; (7) home health care
2 services; (8) private duty nursing service; (9) clinic
3 services; (10) dental services, including prevention and
4 treatment of periodontal disease and dental caries disease for
5 pregnant women, provided by an individual licensed to practice
6 dentistry or dental surgery; for purposes of this item (10),
7 "dental services" means diagnostic, preventive, or corrective
8 procedures provided by or under the supervision of a dentist in
9 the practice of his or her profession; (11) physical therapy
10 and related services; (12) prescribed drugs, dentures, and
11 prosthetic devices; and eyeglasses prescribed by a physician
12 skilled in the diseases of the eye, or by an optometrist,
13 whichever the person may select; (13) other diagnostic,
14 screening, preventive, and rehabilitative services, including
15 to ensure that the individual's need for intervention or
16 treatment of mental disorders or substance use disorders or
17 co-occurring mental health and substance use disorders is
18 determined using a uniform screening, assessment, and
19 evaluation process inclusive of criteria, for children and
20 adults; for purposes of this item (13), a uniform screening,
21 assessment, and evaluation process refers to a process that
22 includes an appropriate evaluation and, as warranted, a
23 referral; "uniform" does not mean the use of a singular
24 instrument, tool, or process that all must utilize; (14)
25 transportation and such other expenses as may be necessary;
26 (15) medical treatment of sexual assault survivors, as defined

1 in Section 1a of the Sexual Assault Survivors Emergency
2 Treatment Act, for injuries sustained as a result of the sexual
3 assault, including examinations and laboratory tests to
4 discover evidence which may be used in criminal proceedings
5 arising from the sexual assault; (16) the diagnosis and
6 treatment of sickle cell anemia; and (17) any other medical
7 care, and any other type of remedial care recognized under the
8 laws of this State, but not including abortions, or induced
9 miscarriages or premature births, unless, in the opinion of a
10 physician, such procedures are necessary for the preservation
11 of the life of the woman seeking such treatment, or except an
12 induced premature birth intended to produce a live viable child
13 and such procedure is necessary for the health of the mother or
14 her unborn child. The Illinois Department, by rule, shall
15 prohibit any physician from providing medical assistance to
16 anyone eligible therefor under this Code where such physician
17 has been found guilty of performing an abortion procedure in a
18 wilful and wanton manner upon a woman who was not pregnant at
19 the time such abortion procedure was performed. The term "any
20 other type of remedial care" shall include nursing care and
21 nursing home service for persons who rely on treatment by
22 spiritual means alone through prayer for healing.

23 Notwithstanding any other provision of this Section, a
24 comprehensive tobacco use cessation program that includes
25 purchasing prescription drugs or prescription medical devices
26 approved by the Food and Drug Administration shall be covered

1 under the medical assistance program under this Article for
2 persons who are otherwise eligible for assistance under this
3 Article.

4 Notwithstanding any other provision of this Code, the
5 Illinois Department may not require, as a condition of payment
6 for any laboratory test authorized under this Article, that a
7 physician's handwritten signature appear on the laboratory
8 test order form. The Illinois Department may, however, impose
9 other appropriate requirements regarding laboratory test order
10 documentation.

11 Upon receipt of federal approval of an amendment to the
12 Illinois Title XIX State Plan for this purpose, the Department
13 shall authorize the Chicago Public Schools (CPS) to procure a
14 vendor or vendors to manufacture eyeglasses for individuals
15 enrolled in a school within the CPS system. CPS shall ensure
16 that its vendor or vendors are enrolled as providers in the
17 medical assistance program and in any capitated Medicaid
18 managed care entity (MCE) serving individuals enrolled in a
19 school within the CPS system. Under any contract procured under
20 this provision, the vendor or vendors must serve only
21 individuals enrolled in a school within the CPS system. Claims
22 for services provided by CPS's vendor or vendors to recipients
23 of benefits in the medical assistance program under this Code,
24 the Children's Health Insurance Program, or the Covering ALL
25 KIDS Health Insurance Program shall be submitted to the
26 Department or the MCE in which the individual is enrolled for

1 payment and shall be reimbursed at the Department's or the
2 MCE's established rates or rate methodologies for eyeglasses.

3 On and after July 1, 2012, the Department of Healthcare and
4 Family Services may provide the following services to persons
5 eligible for assistance under this Article who are
6 participating in education, training or employment programs
7 operated by the Department of Human Services as successor to
8 the Department of Public Aid:

9 (1) dental services provided by or under the
10 supervision of a dentist; and

11 (2) eyeglasses prescribed by a physician skilled in the
12 diseases of the eye, or by an optometrist, whichever the
13 person may select.

14 Notwithstanding any other provision of this Code and
15 subject to federal approval, the Department may adopt rules to
16 allow a dentist who is volunteering his or her service at no
17 cost to render dental services through an enrolled
18 not-for-profit health clinic without the dentist personally
19 enrolling as a participating provider in the medical assistance
20 program. A not-for-profit health clinic shall include a public
21 health clinic or Federally Qualified Health Center or other
22 enrolled provider, as determined by the Department, through
23 which dental services covered under this Section are performed.
24 The Department shall establish a process for payment of claims
25 for reimbursement for covered dental services rendered under
26 this provision.

1 The Illinois Department, by rule, may distinguish and
2 classify the medical services to be provided only in accordance
3 with the classes of persons designated in Section 5-2.

4 The Department of Healthcare and Family Services must
5 provide coverage and reimbursement for amino acid-based
6 elemental formulas, regardless of delivery method, for the
7 diagnosis and treatment of (i) eosinophilic disorders and (ii)
8 short bowel syndrome when the prescribing physician has issued
9 a written order stating that the amino acid-based elemental
10 formula is medically necessary.

11 The Illinois Department shall authorize the provision of,
12 and shall authorize payment for, screening by low-dose
13 mammography for the presence of occult breast cancer for women
14 35 years of age or older who are eligible for medical
15 assistance under this Article, as follows:

16 (A) A baseline mammogram for women 35 to 39 years of
17 age.

18 (B) An annual mammogram for women 40 years of age or
19 older.

20 (C) A mammogram at the age and intervals considered
21 medically necessary by the woman's health care provider for
22 women under 40 years of age and having a family history of
23 breast cancer, prior personal history of breast cancer,
24 positive genetic testing, or other risk factors.

25 (D) A comprehensive ultrasound screening of an entire
26 breast or breasts if a mammogram demonstrates

1 heterogeneous or dense breast tissue, when medically
2 necessary as determined by a physician licensed to practice
3 medicine in all of its branches.

4 (E) A screening MRI when medically necessary, as
5 determined by a physician licensed to practice medicine in
6 all of its branches.

7 All screenings shall include a physical breast exam,
8 instruction on self-examination and information regarding the
9 frequency of self-examination and its value as a preventative
10 tool. For purposes of this Section, "low-dose mammography"
11 means the x-ray examination of the breast using equipment
12 dedicated specifically for mammography, including the x-ray
13 tube, filter, compression device, and image receptor, with an
14 average radiation exposure delivery of less than one rad per
15 breast for 2 views of an average size breast. The term also
16 includes digital mammography and includes breast
17 tomosynthesis. As used in this Section, the term "breast
18 tomosynthesis" means a radiologic procedure that involves the
19 acquisition of projection images over the stationary breast to
20 produce cross-sectional digital three-dimensional images of
21 the breast. If, at any time, the Secretary of the United States
22 Department of Health and Human Services, or its successor
23 agency, promulgates rules or regulations to be published in the
24 Federal Register or publishes a comment in the Federal Register
25 or issues an opinion, guidance, or other action that would
26 require the State, pursuant to any provision of the Patient

1 Protection and Affordable Care Act (Public Law 111-148),
2 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
3 successor provision, to defray the cost of any coverage for
4 breast tomosynthesis outlined in this paragraph, then the
5 requirement that an insurer cover breast tomosynthesis is
6 inoperative other than any such coverage authorized under
7 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
8 the State shall not assume any obligation for the cost of
9 coverage for breast tomosynthesis set forth in this paragraph.

10 On and after January 1, 2016, the Department shall ensure
11 that all networks of care for adult clients of the Department
12 include access to at least one breast imaging Center of Imaging
13 Excellence as certified by the American College of Radiology.

14 On and after January 1, 2012, providers participating in a
15 quality improvement program approved by the Department shall be
16 reimbursed for screening and diagnostic mammography at the same
17 rate as the Medicare program's rates, including the increased
18 reimbursement for digital mammography.

19 The Department shall convene an expert panel including
20 representatives of hospitals, free-standing mammography
21 facilities, and doctors, including radiologists, to establish
22 quality standards for mammography.

23 On and after January 1, 2017, providers participating in a
24 breast cancer treatment quality improvement program approved
25 by the Department shall be reimbursed for breast cancer
26 treatment at a rate that is no lower than 95% of the Medicare

1 program's rates for the data elements included in the breast
2 cancer treatment quality program.

3 The Department shall convene an expert panel, including
4 representatives of hospitals, free standing breast cancer
5 treatment centers, breast cancer quality organizations, and
6 doctors, including breast surgeons, reconstructive breast
7 surgeons, oncologists, and primary care providers to establish
8 quality standards for breast cancer treatment.

9 Subject to federal approval, the Department shall
10 establish a rate methodology for mammography at federally
11 qualified health centers and other encounter-rate clinics.
12 These clinics or centers may also collaborate with other
13 hospital-based mammography facilities. By January 1, 2016, the
14 Department shall report to the General Assembly on the status
15 of the provision set forth in this paragraph.

16 The Department shall establish a methodology to remind
17 women who are age-appropriate for screening mammography, but
18 who have not received a mammogram within the previous 18
19 months, of the importance and benefit of screening mammography.
20 The Department shall work with experts in breast cancer
21 outreach and patient navigation to optimize these reminders and
22 shall establish a methodology for evaluating their
23 effectiveness and modifying the methodology based on the
24 evaluation.

25 The Department shall establish a performance goal for
26 primary care providers with respect to their female patients

1 over age 40 receiving an annual mammogram. This performance
2 goal shall be used to provide additional reimbursement in the
3 form of a quality performance bonus to primary care providers
4 who meet that goal.

5 The Department shall devise a means of case-managing or
6 patient navigation for beneficiaries diagnosed with breast
7 cancer. This program shall initially operate as a pilot program
8 in areas of the State with the highest incidence of mortality
9 related to breast cancer. At least one pilot program site shall
10 be in the metropolitan Chicago area and at least one site shall
11 be outside the metropolitan Chicago area. On or after July 1,
12 2016, the pilot program shall be expanded to include one site
13 in western Illinois, one site in southern Illinois, one site in
14 central Illinois, and 4 sites within metropolitan Chicago. An
15 evaluation of the pilot program shall be carried out measuring
16 health outcomes and cost of care for those served by the pilot
17 program compared to similarly situated patients who are not
18 served by the pilot program.

19 The Department shall require all networks of care to
20 develop a means either internally or by contract with experts
21 in navigation and community outreach to navigate cancer
22 patients to comprehensive care in a timely fashion. The
23 Department shall require all networks of care to include access
24 for patients diagnosed with cancer to at least one academic
25 commission on cancer-accredited cancer program as an
26 in-network covered benefit.

1 Any medical or health care provider shall immediately
2 recommend, to any pregnant woman who is being provided prenatal
3 services and is suspected of drug abuse or is addicted as
4 defined in the Alcoholism and Other Drug Abuse and Dependency
5 Act, referral to a local substance abuse treatment provider
6 licensed by the Department of Human Services or to a licensed
7 hospital which provides substance abuse treatment services.
8 The Department of Healthcare and Family Services shall assure
9 coverage for the cost of treatment of the drug abuse or
10 addiction for pregnant recipients in accordance with the
11 Illinois Medicaid Program in conjunction with the Department of
12 Human Services.

13 All medical providers providing medical assistance to
14 pregnant women under this Code shall receive information from
15 the Department on the availability of services under the Drug
16 Free Families with a Future or any comparable program providing
17 case management services for addicted women, including
18 information on appropriate referrals for other social services
19 that may be needed by addicted women in addition to treatment
20 for addiction.

21 The Illinois Department, in cooperation with the
22 Departments of Human Services (as successor to the Department
23 of Alcoholism and Substance Abuse) and Public Health, through a
24 public awareness campaign, may provide information concerning
25 treatment for alcoholism and drug abuse and addiction, prenatal
26 health care, and other pertinent programs directed at reducing

1 the number of drug-affected infants born to recipients of
2 medical assistance.

3 Neither the Department of Healthcare and Family Services
4 nor the Department of Human Services shall sanction the
5 recipient solely on the basis of her substance abuse.

6 The Illinois Department shall establish such regulations
7 governing the dispensing of health services under this Article
8 as it shall deem appropriate. The Department should seek the
9 advice of formal professional advisory committees appointed by
10 the Director of the Illinois Department for the purpose of
11 providing regular advice on policy and administrative matters,
12 information dissemination and educational activities for
13 medical and health care providers, and consistency in
14 procedures to the Illinois Department.

15 The Illinois Department may develop and contract with
16 Partnerships of medical providers to arrange medical services
17 for persons eligible under Section 5-2 of this Code.
18 Implementation of this Section may be by demonstration projects
19 in certain geographic areas. The Partnership shall be
20 represented by a sponsor organization. The Department, by rule,
21 shall develop qualifications for sponsors of Partnerships.
22 Nothing in this Section shall be construed to require that the
23 sponsor organization be a medical organization.

24 The sponsor must negotiate formal written contracts with
25 medical providers for physician services, inpatient and
26 outpatient hospital care, home health services, treatment for

1 alcoholism and substance abuse, and other services determined
2 necessary by the Illinois Department by rule for delivery by
3 Partnerships. Physician services must include prenatal and
4 obstetrical care. The Illinois Department shall reimburse
5 medical services delivered by Partnership providers to clients
6 in target areas according to provisions of this Article and the
7 Illinois Health Finance Reform Act, except that:

8 (1) Physicians participating in a Partnership and
9 providing certain services, which shall be determined by
10 the Illinois Department, to persons in areas covered by the
11 Partnership may receive an additional surcharge for such
12 services.

13 (2) The Department may elect to consider and negotiate
14 financial incentives to encourage the development of
15 Partnerships and the efficient delivery of medical care.

16 (3) Persons receiving medical services through
17 Partnerships may receive medical and case management
18 services above the level usually offered through the
19 medical assistance program.

20 Medical providers shall be required to meet certain
21 qualifications to participate in Partnerships to ensure the
22 delivery of high quality medical services. These
23 qualifications shall be determined by rule of the Illinois
24 Department and may be higher than qualifications for
25 participation in the medical assistance program. Partnership
26 sponsors may prescribe reasonable additional qualifications

1 for participation by medical providers, only with the prior
2 written approval of the Illinois Department.

3 Nothing in this Section shall limit the free choice of
4 practitioners, hospitals, and other providers of medical
5 services by clients. In order to ensure patient freedom of
6 choice, the Illinois Department shall immediately promulgate
7 all rules and take all other necessary actions so that provided
8 services may be accessed from therapeutically certified
9 optometrists to the full extent of the Illinois Optometric
10 Practice Act of 1987 without discriminating between service
11 providers.

12 The Department shall apply for a waiver from the United
13 States Health Care Financing Administration to allow for the
14 implementation of Partnerships under this Section.

15 The Illinois Department shall require health care
16 providers to maintain records that document the medical care
17 and services provided to recipients of Medical Assistance under
18 this Article. Such records must be retained for a period of not
19 less than 6 years from the date of service or as provided by
20 applicable State law, whichever period is longer, except that
21 if an audit is initiated within the required retention period
22 then the records must be retained until the audit is completed
23 and every exception is resolved. The Illinois Department shall
24 require health care providers to make available, when
25 authorized by the patient, in writing, the medical records in a
26 timely fashion to other health care providers who are treating

1 or serving persons eligible for Medical Assistance under this
2 Article. All dispensers of medical services shall be required
3 to maintain and retain business and professional records
4 sufficient to fully and accurately document the nature, scope,
5 details and receipt of the health care provided to persons
6 eligible for medical assistance under this Code, in accordance
7 with regulations promulgated by the Illinois Department. The
8 rules and regulations shall require that proof of the receipt
9 of prescription drugs, dentures, prosthetic devices and
10 eyeglasses by eligible persons under this Section accompany
11 each claim for reimbursement submitted by the dispenser of such
12 medical services. No such claims for reimbursement shall be
13 approved for payment by the Illinois Department without such
14 proof of receipt, unless the Illinois Department shall have put
15 into effect and shall be operating a system of post-payment
16 audit and review which shall, on a sampling basis, be deemed
17 adequate by the Illinois Department to assure that such drugs,
18 dentures, prosthetic devices and eyeglasses for which payment
19 is being made are actually being received by eligible
20 recipients. Within 90 days after September 16, 1984 (the
21 effective date of Public Act 83-1439), the Illinois Department
22 shall establish a current list of acquisition costs for all
23 prosthetic devices and any other items recognized as medical
24 equipment and supplies reimbursable under this Article and
25 shall update such list on a quarterly basis, except that the
26 acquisition costs of all prescription drugs shall be updated no

1 less frequently than every 30 days as required by Section
2 5-5.12.

3 The rules and regulations of the Illinois Department shall
4 require that a written statement including the required opinion
5 of a physician shall accompany any claim for reimbursement for
6 abortions, or induced miscarriages or premature births. This
7 statement shall indicate what procedures were used in providing
8 such medical services.

9 Notwithstanding any other law to the contrary, the Illinois
10 Department shall, within 365 days after July 22, 2013 (the
11 effective date of Public Act 98-104), establish procedures to
12 permit skilled care facilities licensed under the Nursing Home
13 Care Act to submit monthly billing claims for reimbursement
14 purposes. Following development of these procedures, the
15 Department shall, by July 1, 2016, test the viability of the
16 new system and implement any necessary operational or
17 structural changes to its information technology platforms in
18 order to allow for the direct acceptance and payment of nursing
19 home claims.

20 Notwithstanding any other law to the contrary, the Illinois
21 Department shall, within 365 days after August 15, 2014 (the
22 effective date of Public Act 98-963), establish procedures to
23 permit ID/DD facilities licensed under the ID/DD Community Care
24 Act and MC/DD facilities licensed under the MC/DD Act to submit
25 monthly billing claims for reimbursement purposes. Following
26 development of these procedures, the Department shall have an

1 additional 365 days to test the viability of the new system and
2 to ensure that any necessary operational or structural changes
3 to its information technology platforms are implemented.

4 The Illinois Department shall require all dispensers of
5 medical services, other than an individual practitioner or
6 group of practitioners, desiring to participate in the Medical
7 Assistance program established under this Article to disclose
8 all financial, beneficial, ownership, equity, surety or other
9 interests in any and all firms, corporations, partnerships,
10 associations, business enterprises, joint ventures, agencies,
11 institutions or other legal entities providing any form of
12 health care services in this State under this Article.

13 The Illinois Department may require that all dispensers of
14 medical services desiring to participate in the medical
15 assistance program established under this Article disclose,
16 under such terms and conditions as the Illinois Department may
17 by rule establish, all inquiries from clients and attorneys
18 regarding medical bills paid by the Illinois Department, which
19 inquiries could indicate potential existence of claims or liens
20 for the Illinois Department.

21 Enrollment of a vendor shall be subject to a provisional
22 period and shall be conditional for one year. During the period
23 of conditional enrollment, the Department may terminate the
24 vendor's eligibility to participate in, or may disenroll the
25 vendor from, the medical assistance program without cause.
26 Unless otherwise specified, such termination of eligibility or

1 disenrollment is not subject to the Department's hearing
2 process. However, a disenrolled vendor may reapply without
3 penalty.

4 The Department has the discretion to limit the conditional
5 enrollment period for vendors based upon category of risk of
6 the vendor.

7 Prior to enrollment and during the conditional enrollment
8 period in the medical assistance program, all vendors shall be
9 subject to enhanced oversight, screening, and review based on
10 the risk of fraud, waste, and abuse that is posed by the
11 category of risk of the vendor. The Illinois Department shall
12 establish the procedures for oversight, screening, and review,
13 which may include, but need not be limited to: criminal and
14 financial background checks; fingerprinting; license,
15 certification, and authorization verifications; unscheduled or
16 unannounced site visits; database checks; prepayment audit
17 reviews; audits; payment caps; payment suspensions; and other
18 screening as required by federal or State law.

19 The Department shall define or specify the following: (i)
20 by provider notice, the "category of risk of the vendor" for
21 each type of vendor, which shall take into account the level of
22 screening applicable to a particular category of vendor under
23 federal law and regulations; (ii) by rule or provider notice,
24 the maximum length of the conditional enrollment period for
25 each category of risk of the vendor; and (iii) by rule, the
26 hearing rights, if any, afforded to a vendor in each category

1 of risk of the vendor that is terminated or disenrolled during
2 the conditional enrollment period.

3 To be eligible for payment consideration, a vendor's
4 payment claim or bill, either as an initial claim or as a
5 resubmitted claim following prior rejection, must be received
6 by the Illinois Department, or its fiscal intermediary, no
7 later than 180 days after the latest date on the claim on which
8 medical goods or services were provided, with the following
9 exceptions:

10 (1) In the case of a provider whose enrollment is in
11 process by the Illinois Department, the 180-day period
12 shall not begin until the date on the written notice from
13 the Illinois Department that the provider enrollment is
14 complete.

15 (2) In the case of errors attributable to the Illinois
16 Department or any of its claims processing intermediaries
17 which result in an inability to receive, process, or
18 adjudicate a claim, the 180-day period shall not begin
19 until the provider has been notified of the error.

20 (3) In the case of a provider for whom the Illinois
21 Department initiates the monthly billing process.

22 (4) In the case of a provider operated by a unit of
23 local government with a population exceeding 3,000,000
24 when local government funds finance federal participation
25 for claims payments.

26 For claims for services rendered during a period for which

1 a recipient received retroactive eligibility, claims must be
2 filed within 180 days after the Department determines the
3 applicant is eligible. For claims for which the Illinois
4 Department is not the primary payer, claims must be submitted
5 to the Illinois Department within 180 days after the final
6 adjudication by the primary payer.

7 In the case of long term care facilities, within 5 days of
8 receipt by the facility of required prescreening information,
9 data for new admissions shall be entered into the Medical
10 Electronic Data Interchange (MEDI) or the Recipient
11 Eligibility Verification (REV) System or successor system, and
12 within 15 days of receipt by the facility of required
13 prescreening information, admission documents shall be
14 submitted through MEDI or REV or shall be submitted directly to
15 the Department of Human Services using required admission
16 forms. Effective September 1, 2014, admission documents,
17 including all prescreening information, must be submitted
18 through MEDI or REV. Confirmation numbers assigned to an
19 accepted transaction shall be retained by a facility to verify
20 timely submittal. Once an admission transaction has been
21 completed, all resubmitted claims following prior rejection
22 are subject to receipt no later than 180 days after the
23 admission transaction has been completed.

24 Claims that are not submitted and received in compliance
25 with the foregoing requirements shall not be eligible for
26 payment under the medical assistance program, and the State

1 shall have no liability for payment of those claims.

2 To the extent consistent with applicable information and
3 privacy, security, and disclosure laws, State and federal
4 agencies and departments shall provide the Illinois Department
5 access to confidential and other information and data necessary
6 to perform eligibility and payment verifications and other
7 Illinois Department functions. This includes, but is not
8 limited to: information pertaining to licensure;
9 certification; earnings; immigration status; citizenship; wage
10 reporting; unearned and earned income; pension income;
11 employment; supplemental security income; social security
12 numbers; National Provider Identifier (NPI) numbers; the
13 National Practitioner Data Bank (NPDB); program and agency
14 exclusions; taxpayer identification numbers; tax delinquency;
15 corporate information; and death records.

16 The Illinois Department shall enter into agreements with
17 State agencies and departments, and is authorized to enter into
18 agreements with federal agencies and departments, under which
19 such agencies and departments shall share data necessary for
20 medical assistance program integrity functions and oversight.
21 The Illinois Department shall develop, in cooperation with
22 other State departments and agencies, and in compliance with
23 applicable federal laws and regulations, appropriate and
24 effective methods to share such data. At a minimum, and to the
25 extent necessary to provide data sharing, the Illinois
26 Department shall enter into agreements with State agencies and

1 departments, and is authorized to enter into agreements with
2 federal agencies and departments, including but not limited to:
3 the Secretary of State; the Department of Revenue; the
4 Department of Public Health; the Department of Human Services;
5 and the Department of Financial and Professional Regulation.

6 Beginning in fiscal year 2013, the Illinois Department
7 shall set forth a request for information to identify the
8 benefits of a pre-payment, post-adjudication, and post-edit
9 claims system with the goals of streamlining claims processing
10 and provider reimbursement, reducing the number of pending or
11 rejected claims, and helping to ensure a more transparent
12 adjudication process through the utilization of: (i) provider
13 data verification and provider screening technology; and (ii)
14 clinical code editing; and (iii) pre-pay, pre- or
15 post-adjudicated predictive modeling with an integrated case
16 management system with link analysis. Such a request for
17 information shall not be considered as a request for proposal
18 or as an obligation on the part of the Illinois Department to
19 take any action or acquire any products or services.

20 The Illinois Department shall establish policies,
21 procedures, standards and criteria by rule for the acquisition,
22 repair and replacement of orthotic and prosthetic devices and
23 durable medical equipment. Such rules shall provide, but not be
24 limited to, the following services: (1) immediate repair or
25 replacement of such devices by recipients; and (2) rental,
26 lease, purchase or lease-purchase of durable medical equipment

1 in a cost-effective manner, taking into consideration the
2 recipient's medical prognosis, the extent of the recipient's
3 needs, and the requirements and costs for maintaining such
4 equipment. Subject to prior approval, such rules shall enable a
5 recipient to temporarily acquire and use alternative or
6 substitute devices or equipment pending repairs or
7 replacements of any device or equipment previously authorized
8 for such recipient by the Department. Notwithstanding any
9 provision of Section 5-5f to the contrary, the Department may,
10 by rule, exempt certain replacement wheelchair parts from prior
11 approval and, for wheelchairs, wheelchair parts, wheelchair
12 accessories, and related seating and positioning items,
13 determine the wholesale price by methods other than actual
14 acquisition costs.

15 The Department shall require, by rule, all providers of
16 durable medical equipment to be accredited by an accreditation
17 organization approved by the federal Centers for Medicare and
18 Medicaid Services and recognized by the Department in order to
19 bill the Department for providing durable medical equipment to
20 recipients. No later than 15 months after the effective date of
21 the rule adopted pursuant to this paragraph, all providers must
22 meet the accreditation requirement.

23 The Department shall execute, relative to the nursing home
24 prescreening project, written inter-agency agreements with the
25 Department of Human Services and the Department on Aging, to
26 effect the following: (i) intake procedures and common

1 eligibility criteria for those persons who are receiving
2 non-institutional services; and (ii) the establishment and
3 development of non-institutional services in areas of the State
4 where they are not currently available or are undeveloped; and
5 (iii) notwithstanding any other provision of law, subject to
6 federal approval, on and after July 1, 2012, an increase in the
7 determination of need (DON) scores from 29 to 37 for applicants
8 for institutional and home and community-based long term care;
9 if and only if federal approval is not granted, the Department
10 may, in conjunction with other affected agencies, implement
11 utilization controls or changes in benefit packages to
12 effectuate a similar savings amount for this population; and
13 (iv) no later than July 1, 2013, minimum level of care
14 eligibility criteria for institutional and home and
15 community-based long term care; and (v) no later than October
16 1, 2013, establish procedures to permit long term care
17 providers access to eligibility scores for individuals with an
18 admission date who are seeking or receiving services from the
19 long term care provider. In order to select the minimum level
20 of care eligibility criteria, the Governor shall establish a
21 workgroup that includes affected agency representatives and
22 stakeholders representing the institutional and home and
23 community-based long term care interests. This Section shall
24 not restrict the Department from implementing lower level of
25 care eligibility criteria for community-based services in
26 circumstances where federal approval has been granted.

1 The Illinois Department shall develop and operate, in
2 cooperation with other State Departments and agencies and in
3 compliance with applicable federal laws and regulations,
4 appropriate and effective systems of health care evaluation and
5 programs for monitoring of utilization of health care services
6 and facilities, as it affects persons eligible for medical
7 assistance under this Code.

8 The Illinois Department shall report annually to the
9 General Assembly, no later than the second Friday in April of
10 1979 and each year thereafter, in regard to:

11 (a) actual statistics and trends in utilization of
12 medical services by public aid recipients;

13 (b) actual statistics and trends in the provision of
14 the various medical services by medical vendors;

15 (c) current rate structures and proposed changes in
16 those rate structures for the various medical vendors; and

17 (d) efforts at utilization review and control by the
18 Illinois Department.

19 The period covered by each report shall be the 3 years
20 ending on the June 30 prior to the report. The report shall
21 include suggested legislation for consideration by the General
22 Assembly. The filing of one copy of the report with the
23 Speaker, one copy with the Minority Leader and one copy with
24 the Clerk of the House of Representatives, one copy with the
25 President, one copy with the Minority Leader and one copy with
26 the Secretary of the Senate, one copy with the Legislative

1 Research Unit, and such additional copies with the State
2 Government Report Distribution Center for the General Assembly
3 as is required under paragraph (t) of Section 7 of the State
4 Library Act shall be deemed sufficient to comply with this
5 Section.

6 Rulemaking authority to implement Public Act 95-1045, if
7 any, is conditioned on the rules being adopted in accordance
8 with all provisions of the Illinois Administrative Procedure
9 Act and all rules and procedures of the Joint Committee on
10 Administrative Rules; any purported rule not so adopted, for
11 whatever reason, is unauthorized.

12 On and after July 1, 2012, the Department shall reduce any
13 rate of reimbursement for services or other payments or alter
14 any methodologies authorized by this Code to reduce any rate of
15 reimbursement for services or other payments in accordance with
16 Section 5-5e.

17 Because kidney transplantation can be an appropriate, cost
18 effective alternative to renal dialysis when medically
19 necessary and notwithstanding the provisions of Section 1-11 of
20 this Code, beginning October 1, 2014, the Department shall
21 cover kidney transplantation for noncitizens with end-stage
22 renal disease who are not eligible for comprehensive medical
23 benefits, who meet the residency requirements of Section 5-3 of
24 this Code, and who would otherwise meet the financial
25 requirements of the appropriate class of eligible persons under
26 Section 5-2 of this Code. To qualify for coverage of kidney

1 transplantation, such person must be receiving emergency renal
2 dialysis services covered by the Department. Providers under
3 this Section shall be prior approved and certified by the
4 Department to perform kidney transplantation and the services
5 under this Section shall be limited to services associated with
6 kidney transplantation.

7 Notwithstanding any other provision of this Code to the
8 contrary, on or after July 1, 2015, all FDA approved forms of
9 medication assisted treatment prescribed for the treatment of
10 alcohol dependence or treatment of opioid dependence shall be
11 covered under both fee for service and managed care medical
12 assistance programs for persons who are otherwise eligible for
13 medical assistance under this Article and shall not be subject
14 to any (1) utilization control, other than those established
15 under the American Society of Addiction Medicine patient
16 placement criteria, (2) prior authorization mandate, or (3)
17 lifetime restriction limit mandate.

18 On or after July 1, 2015, opioid antagonists prescribed for
19 the treatment of an opioid overdose, including the medication
20 product, administration devices, and any pharmacy fees related
21 to the dispensing and administration of the opioid antagonist,
22 shall be covered under the medical assistance program for
23 persons who are otherwise eligible for medical assistance under
24 this Article. As used in this Section, "opioid antagonist"
25 means a drug that binds to opioid receptors and blocks or
26 inhibits the effect of opioids acting on those receptors,

1 including, but not limited to, naloxone hydrochloride or any
2 other similarly acting drug approved by the U.S. Food and Drug
3 Administration.

4 Upon federal approval, the Department shall provide
5 coverage and reimbursement for all drugs that are approved for
6 marketing by the federal Food and Drug Administration and that
7 are recommended by the federal Public Health Service or the
8 United States Centers for Disease Control and Prevention for
9 pre-exposure prophylaxis and related pre-exposure prophylaxis
10 services, including, but not limited to, HIV and sexually
11 transmitted infection screening, treatment for sexually
12 transmitted infections, medical monitoring, assorted labs, and
13 counseling to reduce the likelihood of HIV infection among
14 individuals who are not infected with HIV but who are at high
15 risk of HIV infection.

16 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;
17 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.
18 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,
19 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;
20 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-407 (see Section
21 20 of P.A. 99-588 for the effective date of P.A. 99-407);
22 99-433, eff. 8-21-15; 99-480, eff. 9-9-15; 99-588, eff.
23 7-20-16; 99-642, eff. 7-28-16; 99-772, eff. 1-1-17; 99-895,
24 eff. 1-1-17; revised 9-20-16.)

25 (Text of Section after amendment by P.A. 100-538)

1 Sec. 5-5. Medical services. The Illinois Department, by
2 rule, shall determine the quantity and quality of and the rate
3 of reimbursement for the medical assistance for which payment
4 will be authorized, and the medical services to be provided,
5 which may include all or part of the following: (1) inpatient
6 hospital services; (2) outpatient hospital services; (3) other
7 laboratory and X-ray services; (4) skilled nursing home
8 services; (5) physicians' services whether furnished in the
9 office, the patient's home, a hospital, a skilled nursing home,
10 or elsewhere; (6) medical care, or any other type of remedial
11 care furnished by licensed practitioners; (7) home health care
12 services; (8) private duty nursing service; (9) clinic
13 services; (10) dental services, including prevention and
14 treatment of periodontal disease and dental caries disease for
15 pregnant women, provided by an individual licensed to practice
16 dentistry or dental surgery; for purposes of this item (10),
17 "dental services" means diagnostic, preventive, or corrective
18 procedures provided by or under the supervision of a dentist in
19 the practice of his or her profession; (11) physical therapy
20 and related services; (12) prescribed drugs, dentures, and
21 prosthetic devices; and eyeglasses prescribed by a physician
22 skilled in the diseases of the eye, or by an optometrist,
23 whichever the person may select; (13) other diagnostic,
24 screening, preventive, and rehabilitative services, including
25 to ensure that the individual's need for intervention or
26 treatment of mental disorders or substance use disorders or

1 co-occurring mental health and substance use disorders is
2 determined using a uniform screening, assessment, and
3 evaluation process inclusive of criteria, for children and
4 adults; for purposes of this item (13), a uniform screening,
5 assessment, and evaluation process refers to a process that
6 includes an appropriate evaluation and, as warranted, a
7 referral; "uniform" does not mean the use of a singular
8 instrument, tool, or process that all must utilize; (14)
9 transportation and such other expenses as may be necessary;
10 (15) medical treatment of sexual assault survivors, as defined
11 in Section 1a of the Sexual Assault Survivors Emergency
12 Treatment Act, for injuries sustained as a result of the sexual
13 assault, including examinations and laboratory tests to
14 discover evidence which may be used in criminal proceedings
15 arising from the sexual assault; (16) the diagnosis and
16 treatment of sickle cell anemia; and (17) any other medical
17 care, and any other type of remedial care recognized under the
18 laws of this State, except as provided in the No Taxpayer
19 Funding for Abortion Act. The Illinois Department, by rule,
20 shall prohibit any physician from providing medical assistance
21 to anyone eligible therefor under this Code where such
22 physician has been found guilty of performing an abortion
23 procedure in a willful and wanton manner upon a woman who was
24 not pregnant at the time such abortion procedure was performed.
25 The term "any other type of remedial care" shall include
26 nursing care and nursing home service for persons who rely on

1 treatment by spiritual means alone through prayer for healing.

2 Notwithstanding any other provision of this Section, a
3 comprehensive tobacco use cessation program that includes
4 purchasing prescription drugs or prescription medical devices
5 approved by the Food and Drug Administration shall be covered
6 under the medical assistance program under this Article for
7 persons who are otherwise eligible for assistance under this
8 Article.

9 Notwithstanding any other provision of this Code,
10 reproductive health care that is otherwise legal in Illinois
11 shall be covered under the medical assistance program for
12 persons who are otherwise eligible for medical assistance under
13 this Article, except as provided in the No Taxpayer Funding for
14 Abortion Act.

15 Notwithstanding any other provision of this Code, the
16 Illinois Department may not require, as a condition of payment
17 for any laboratory test authorized under this Article, that a
18 physician's handwritten signature appear on the laboratory
19 test order form. The Illinois Department may, however, impose
20 other appropriate requirements regarding laboratory test order
21 documentation.

22 Upon receipt of federal approval of an amendment to the
23 Illinois Title XIX State Plan for this purpose, the Department
24 shall authorize the Chicago Public Schools (CPS) to procure a
25 vendor or vendors to manufacture eyeglasses for individuals
26 enrolled in a school within the CPS system. CPS shall ensure

1 that its vendor or vendors are enrolled as providers in the
2 medical assistance program and in any capitated Medicaid
3 managed care entity (MCE) serving individuals enrolled in a
4 school within the CPS system. Under any contract procured under
5 this provision, the vendor or vendors must serve only
6 individuals enrolled in a school within the CPS system. Claims
7 for services provided by CPS's vendor or vendors to recipients
8 of benefits in the medical assistance program under this Code,
9 the Children's Health Insurance Program, or the Covering ALL
10 KIDS Health Insurance Program shall be submitted to the
11 Department or the MCE in which the individual is enrolled for
12 payment and shall be reimbursed at the Department's or the
13 MCE's established rates or rate methodologies for eyeglasses.

14 On and after July 1, 2012, the Department of Healthcare and
15 Family Services may provide the following services to persons
16 eligible for assistance under this Article who are
17 participating in education, training or employment programs
18 operated by the Department of Human Services as successor to
19 the Department of Public Aid:

20 (1) dental services provided by or under the
21 supervision of a dentist; and

22 (2) eyeglasses prescribed by a physician skilled in the
23 diseases of the eye, or by an optometrist, whichever the
24 person may select.

25 Notwithstanding any other provision of this Code and
26 subject to federal approval, the Department may adopt rules to

1 allow a dentist who is volunteering his or her service at no
2 cost to render dental services through an enrolled
3 not-for-profit health clinic without the dentist personally
4 enrolling as a participating provider in the medical assistance
5 program. A not-for-profit health clinic shall include a public
6 health clinic or Federally Qualified Health Center or other
7 enrolled provider, as determined by the Department, through
8 which dental services covered under this Section are performed.
9 The Department shall establish a process for payment of claims
10 for reimbursement for covered dental services rendered under
11 this provision.

12 The Illinois Department, by rule, may distinguish and
13 classify the medical services to be provided only in accordance
14 with the classes of persons designated in Section 5-2.

15 The Department of Healthcare and Family Services must
16 provide coverage and reimbursement for amino acid-based
17 elemental formulas, regardless of delivery method, for the
18 diagnosis and treatment of (i) eosinophilic disorders and (ii)
19 short bowel syndrome when the prescribing physician has issued
20 a written order stating that the amino acid-based elemental
21 formula is medically necessary.

22 The Illinois Department shall authorize the provision of,
23 and shall authorize payment for, screening by low-dose
24 mammography for the presence of occult breast cancer for women
25 35 years of age or older who are eligible for medical
26 assistance under this Article, as follows:

1 (A) A baseline mammogram for women 35 to 39 years of
2 age.

3 (B) An annual mammogram for women 40 years of age or
4 older.

5 (C) A mammogram at the age and intervals considered
6 medically necessary by the woman's health care provider for
7 women under 40 years of age and having a family history of
8 breast cancer, prior personal history of breast cancer,
9 positive genetic testing, or other risk factors.

10 (D) A comprehensive ultrasound screening of an entire
11 breast or breasts if a mammogram demonstrates
12 heterogeneous or dense breast tissue, when medically
13 necessary as determined by a physician licensed to practice
14 medicine in all of its branches.

15 (E) A screening MRI when medically necessary, as
16 determined by a physician licensed to practice medicine in
17 all of its branches.

18 All screenings shall include a physical breast exam,
19 instruction on self-examination and information regarding the
20 frequency of self-examination and its value as a preventative
21 tool. For purposes of this Section, "low-dose mammography"
22 means the x-ray examination of the breast using equipment
23 dedicated specifically for mammography, including the x-ray
24 tube, filter, compression device, and image receptor, with an
25 average radiation exposure delivery of less than one rad per
26 breast for 2 views of an average size breast. The term also

1 includes digital mammography and includes breast
2 tomosynthesis. As used in this Section, the term "breast
3 tomosynthesis" means a radiologic procedure that involves the
4 acquisition of projection images over the stationary breast to
5 produce cross-sectional digital three-dimensional images of
6 the breast. If, at any time, the Secretary of the United States
7 Department of Health and Human Services, or its successor
8 agency, promulgates rules or regulations to be published in the
9 Federal Register or publishes a comment in the Federal Register
10 or issues an opinion, guidance, or other action that would
11 require the State, pursuant to any provision of the Patient
12 Protection and Affordable Care Act (Public Law 111-148),
13 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
14 successor provision, to defray the cost of any coverage for
15 breast tomosynthesis outlined in this paragraph, then the
16 requirement that an insurer cover breast tomosynthesis is
17 inoperative other than any such coverage authorized under
18 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
19 the State shall not assume any obligation for the cost of
20 coverage for breast tomosynthesis set forth in this paragraph.

21 On and after January 1, 2016, the Department shall ensure
22 that all networks of care for adult clients of the Department
23 include access to at least one breast imaging Center of Imaging
24 Excellence as certified by the American College of Radiology.

25 On and after January 1, 2012, providers participating in a
26 quality improvement program approved by the Department shall be

1 reimbursed for screening and diagnostic mammography at the same
2 rate as the Medicare program's rates, including the increased
3 reimbursement for digital mammography.

4 The Department shall convene an expert panel including
5 representatives of hospitals, free-standing mammography
6 facilities, and doctors, including radiologists, to establish
7 quality standards for mammography.

8 On and after January 1, 2017, providers participating in a
9 breast cancer treatment quality improvement program approved
10 by the Department shall be reimbursed for breast cancer
11 treatment at a rate that is no lower than 95% of the Medicare
12 program's rates for the data elements included in the breast
13 cancer treatment quality program.

14 The Department shall convene an expert panel, including
15 representatives of hospitals, free standing breast cancer
16 treatment centers, breast cancer quality organizations, and
17 doctors, including breast surgeons, reconstructive breast
18 surgeons, oncologists, and primary care providers to establish
19 quality standards for breast cancer treatment.

20 Subject to federal approval, the Department shall
21 establish a rate methodology for mammography at federally
22 qualified health centers and other encounter-rate clinics.
23 These clinics or centers may also collaborate with other
24 hospital-based mammography facilities. By January 1, 2016, the
25 Department shall report to the General Assembly on the status
26 of the provision set forth in this paragraph.

1 The Department shall establish a methodology to remind
2 women who are age-appropriate for screening mammography, but
3 who have not received a mammogram within the previous 18
4 months, of the importance and benefit of screening mammography.
5 The Department shall work with experts in breast cancer
6 outreach and patient navigation to optimize these reminders and
7 shall establish a methodology for evaluating their
8 effectiveness and modifying the methodology based on the
9 evaluation.

10 The Department shall establish a performance goal for
11 primary care providers with respect to their female patients
12 over age 40 receiving an annual mammogram. This performance
13 goal shall be used to provide additional reimbursement in the
14 form of a quality performance bonus to primary care providers
15 who meet that goal.

16 The Department shall devise a means of case-managing or
17 patient navigation for beneficiaries diagnosed with breast
18 cancer. This program shall initially operate as a pilot program
19 in areas of the State with the highest incidence of mortality
20 related to breast cancer. At least one pilot program site shall
21 be in the metropolitan Chicago area and at least one site shall
22 be outside the metropolitan Chicago area. On or after July 1,
23 2016, the pilot program shall be expanded to include one site
24 in western Illinois, one site in southern Illinois, one site in
25 central Illinois, and 4 sites within metropolitan Chicago. An
26 evaluation of the pilot program shall be carried out measuring

1 health outcomes and cost of care for those served by the pilot
2 program compared to similarly situated patients who are not
3 served by the pilot program.

4 The Department shall require all networks of care to
5 develop a means either internally or by contract with experts
6 in navigation and community outreach to navigate cancer
7 patients to comprehensive care in a timely fashion. The
8 Department shall require all networks of care to include access
9 for patients diagnosed with cancer to at least one academic
10 commission on cancer-accredited cancer program as an
11 in-network covered benefit.

12 Any medical or health care provider shall immediately
13 recommend, to any pregnant woman who is being provided prenatal
14 services and is suspected of drug abuse or is addicted as
15 defined in the Alcoholism and Other Drug Abuse and Dependency
16 Act, referral to a local substance abuse treatment provider
17 licensed by the Department of Human Services or to a licensed
18 hospital which provides substance abuse treatment services.
19 The Department of Healthcare and Family Services shall assure
20 coverage for the cost of treatment of the drug abuse or
21 addiction for pregnant recipients in accordance with the
22 Illinois Medicaid Program in conjunction with the Department of
23 Human Services.

24 All medical providers providing medical assistance to
25 pregnant women under this Code shall receive information from
26 the Department on the availability of services under the Drug

1 Free Families with a Future or any comparable program providing
2 case management services for addicted women, including
3 information on appropriate referrals for other social services
4 that may be needed by addicted women in addition to treatment
5 for addiction.

6 The Illinois Department, in cooperation with the
7 Departments of Human Services (as successor to the Department
8 of Alcoholism and Substance Abuse) and Public Health, through a
9 public awareness campaign, may provide information concerning
10 treatment for alcoholism and drug abuse and addiction, prenatal
11 health care, and other pertinent programs directed at reducing
12 the number of drug-affected infants born to recipients of
13 medical assistance.

14 Neither the Department of Healthcare and Family Services
15 nor the Department of Human Services shall sanction the
16 recipient solely on the basis of her substance abuse.

17 The Illinois Department shall establish such regulations
18 governing the dispensing of health services under this Article
19 as it shall deem appropriate. The Department should seek the
20 advice of formal professional advisory committees appointed by
21 the Director of the Illinois Department for the purpose of
22 providing regular advice on policy and administrative matters,
23 information dissemination and educational activities for
24 medical and health care providers, and consistency in
25 procedures to the Illinois Department.

26 The Illinois Department may develop and contract with

1 Partnerships of medical providers to arrange medical services
2 for persons eligible under Section 5-2 of this Code.
3 Implementation of this Section may be by demonstration projects
4 in certain geographic areas. The Partnership shall be
5 represented by a sponsor organization. The Department, by rule,
6 shall develop qualifications for sponsors of Partnerships.
7 Nothing in this Section shall be construed to require that the
8 sponsor organization be a medical organization.

9 The sponsor must negotiate formal written contracts with
10 medical providers for physician services, inpatient and
11 outpatient hospital care, home health services, treatment for
12 alcoholism and substance abuse, and other services determined
13 necessary by the Illinois Department by rule for delivery by
14 Partnerships. Physician services must include prenatal and
15 obstetrical care. The Illinois Department shall reimburse
16 medical services delivered by Partnership providers to clients
17 in target areas according to provisions of this Article and the
18 Illinois Health Finance Reform Act, except that:

19 (1) Physicians participating in a Partnership and
20 providing certain services, which shall be determined by
21 the Illinois Department, to persons in areas covered by the
22 Partnership may receive an additional surcharge for such
23 services.

24 (2) The Department may elect to consider and negotiate
25 financial incentives to encourage the development of
26 Partnerships and the efficient delivery of medical care.

1 (3) Persons receiving medical services through
2 Partnerships may receive medical and case management
3 services above the level usually offered through the
4 medical assistance program.

5 Medical providers shall be required to meet certain
6 qualifications to participate in Partnerships to ensure the
7 delivery of high quality medical services. These
8 qualifications shall be determined by rule of the Illinois
9 Department and may be higher than qualifications for
10 participation in the medical assistance program. Partnership
11 sponsors may prescribe reasonable additional qualifications
12 for participation by medical providers, only with the prior
13 written approval of the Illinois Department.

14 Nothing in this Section shall limit the free choice of
15 practitioners, hospitals, and other providers of medical
16 services by clients. In order to ensure patient freedom of
17 choice, the Illinois Department shall immediately promulgate
18 all rules and take all other necessary actions so that provided
19 services may be accessed from therapeutically certified
20 optometrists to the full extent of the Illinois Optometric
21 Practice Act of 1987 without discriminating between service
22 providers.

23 The Department shall apply for a waiver from the United
24 States Health Care Financing Administration to allow for the
25 implementation of Partnerships under this Section.

26 The Illinois Department shall require health care

1 providers to maintain records that document the medical care
2 and services provided to recipients of Medical Assistance under
3 this Article. Such records must be retained for a period of not
4 less than 6 years from the date of service or as provided by
5 applicable State law, whichever period is longer, except that
6 if an audit is initiated within the required retention period
7 then the records must be retained until the audit is completed
8 and every exception is resolved. The Illinois Department shall
9 require health care providers to make available, when
10 authorized by the patient, in writing, the medical records in a
11 timely fashion to other health care providers who are treating
12 or serving persons eligible for Medical Assistance under this
13 Article. All dispensers of medical services shall be required
14 to maintain and retain business and professional records
15 sufficient to fully and accurately document the nature, scope,
16 details and receipt of the health care provided to persons
17 eligible for medical assistance under this Code, in accordance
18 with regulations promulgated by the Illinois Department. The
19 rules and regulations shall require that proof of the receipt
20 of prescription drugs, dentures, prosthetic devices and
21 eyeglasses by eligible persons under this Section accompany
22 each claim for reimbursement submitted by the dispenser of such
23 medical services. No such claims for reimbursement shall be
24 approved for payment by the Illinois Department without such
25 proof of receipt, unless the Illinois Department shall have put
26 into effect and shall be operating a system of post-payment

1 audit and review which shall, on a sampling basis, be deemed
2 adequate by the Illinois Department to assure that such drugs,
3 dentures, prosthetic devices and eyeglasses for which payment
4 is being made are actually being received by eligible
5 recipients. Within 90 days after September 16, 1984 (the
6 effective date of Public Act 83-1439), the Illinois Department
7 shall establish a current list of acquisition costs for all
8 prosthetic devices and any other items recognized as medical
9 equipment and supplies reimbursable under this Article and
10 shall update such list on a quarterly basis, except that the
11 acquisition costs of all prescription drugs shall be updated no
12 less frequently than every 30 days as required by Section
13 5-5.12.

14 The rules and regulations of the Illinois Department shall
15 require that a written statement including the required opinion
16 of a physician shall accompany any claim for reimbursement for
17 abortions or induced miscarriages or premature births. This
18 statement shall indicate what procedures were used in providing
19 such medical services.

20 Notwithstanding any other law to the contrary, the Illinois
21 Department shall, within 365 days after July 22, 2013 (the
22 effective date of Public Act 98-104), establish procedures to
23 permit skilled care facilities licensed under the Nursing Home
24 Care Act to submit monthly billing claims for reimbursement
25 purposes. Following development of these procedures, the
26 Department shall, by July 1, 2016, test the viability of the

1 new system and implement any necessary operational or
2 structural changes to its information technology platforms in
3 order to allow for the direct acceptance and payment of nursing
4 home claims.

5 Notwithstanding any other law to the contrary, the Illinois
6 Department shall, within 365 days after August 15, 2014 (the
7 effective date of Public Act 98-963), establish procedures to
8 permit ID/DD facilities licensed under the ID/DD Community Care
9 Act and MC/DD facilities licensed under the MC/DD Act to submit
10 monthly billing claims for reimbursement purposes. Following
11 development of these procedures, the Department shall have an
12 additional 365 days to test the viability of the new system and
13 to ensure that any necessary operational or structural changes
14 to its information technology platforms are implemented.

15 The Illinois Department shall require all dispensers of
16 medical services, other than an individual practitioner or
17 group of practitioners, desiring to participate in the Medical
18 Assistance program established under this Article to disclose
19 all financial, beneficial, ownership, equity, surety or other
20 interests in any and all firms, corporations, partnerships,
21 associations, business enterprises, joint ventures, agencies,
22 institutions or other legal entities providing any form of
23 health care services in this State under this Article.

24 The Illinois Department may require that all dispensers of
25 medical services desiring to participate in the medical
26 assistance program established under this Article disclose,

1 under such terms and conditions as the Illinois Department may
2 by rule establish, all inquiries from clients and attorneys
3 regarding medical bills paid by the Illinois Department, which
4 inquiries could indicate potential existence of claims or liens
5 for the Illinois Department.

6 Enrollment of a vendor shall be subject to a provisional
7 period and shall be conditional for one year. During the period
8 of conditional enrollment, the Department may terminate the
9 vendor's eligibility to participate in, or may disenroll the
10 vendor from, the medical assistance program without cause.
11 Unless otherwise specified, such termination of eligibility or
12 disenrollment is not subject to the Department's hearing
13 process. However, a disenrolled vendor may reapply without
14 penalty.

15 The Department has the discretion to limit the conditional
16 enrollment period for vendors based upon category of risk of
17 the vendor.

18 Prior to enrollment and during the conditional enrollment
19 period in the medical assistance program, all vendors shall be
20 subject to enhanced oversight, screening, and review based on
21 the risk of fraud, waste, and abuse that is posed by the
22 category of risk of the vendor. The Illinois Department shall
23 establish the procedures for oversight, screening, and review,
24 which may include, but need not be limited to: criminal and
25 financial background checks; fingerprinting; license,
26 certification, and authorization verifications; unscheduled or

1 unannounced site visits; database checks; prepayment audit
2 reviews; audits; payment caps; payment suspensions; and other
3 screening as required by federal or State law.

4 The Department shall define or specify the following: (i)
5 by provider notice, the "category of risk of the vendor" for
6 each type of vendor, which shall take into account the level of
7 screening applicable to a particular category of vendor under
8 federal law and regulations; (ii) by rule or provider notice,
9 the maximum length of the conditional enrollment period for
10 each category of risk of the vendor; and (iii) by rule, the
11 hearing rights, if any, afforded to a vendor in each category
12 of risk of the vendor that is terminated or disenrolled during
13 the conditional enrollment period.

14 To be eligible for payment consideration, a vendor's
15 payment claim or bill, either as an initial claim or as a
16 resubmitted claim following prior rejection, must be received
17 by the Illinois Department, or its fiscal intermediary, no
18 later than 180 days after the latest date on the claim on which
19 medical goods or services were provided, with the following
20 exceptions:

21 (1) In the case of a provider whose enrollment is in
22 process by the Illinois Department, the 180-day period
23 shall not begin until the date on the written notice from
24 the Illinois Department that the provider enrollment is
25 complete.

26 (2) In the case of errors attributable to the Illinois

1 Department or any of its claims processing intermediaries
2 which result in an inability to receive, process, or
3 adjudicate a claim, the 180-day period shall not begin
4 until the provider has been notified of the error.

5 (3) In the case of a provider for whom the Illinois
6 Department initiates the monthly billing process.

7 (4) In the case of a provider operated by a unit of
8 local government with a population exceeding 3,000,000
9 when local government funds finance federal participation
10 for claims payments.

11 For claims for services rendered during a period for which
12 a recipient received retroactive eligibility, claims must be
13 filed within 180 days after the Department determines the
14 applicant is eligible. For claims for which the Illinois
15 Department is not the primary payer, claims must be submitted
16 to the Illinois Department within 180 days after the final
17 adjudication by the primary payer.

18 In the case of long term care facilities, within 5 days of
19 receipt by the facility of required prescreening information,
20 data for new admissions shall be entered into the Medical
21 Electronic Data Interchange (MEDI) or the Recipient
22 Eligibility Verification (REV) System or successor system, and
23 within 15 days of receipt by the facility of required
24 prescreening information, admission documents shall be
25 submitted through MEDI or REV or shall be submitted directly to
26 the Department of Human Services using required admission

1 forms. Effective September 1, 2014, admission documents,
2 including all prescreening information, must be submitted
3 through MEDI or REV. Confirmation numbers assigned to an
4 accepted transaction shall be retained by a facility to verify
5 timely submittal. Once an admission transaction has been
6 completed, all resubmitted claims following prior rejection
7 are subject to receipt no later than 180 days after the
8 admission transaction has been completed.

9 Claims that are not submitted and received in compliance
10 with the foregoing requirements shall not be eligible for
11 payment under the medical assistance program, and the State
12 shall have no liability for payment of those claims.

13 To the extent consistent with applicable information and
14 privacy, security, and disclosure laws, State and federal
15 agencies and departments shall provide the Illinois Department
16 access to confidential and other information and data necessary
17 to perform eligibility and payment verifications and other
18 Illinois Department functions. This includes, but is not
19 limited to: information pertaining to licensure;
20 certification; earnings; immigration status; citizenship; wage
21 reporting; unearned and earned income; pension income;
22 employment; supplemental security income; social security
23 numbers; National Provider Identifier (NPI) numbers; the
24 National Practitioner Data Bank (NPDB); program and agency
25 exclusions; taxpayer identification numbers; tax delinquency;
26 corporate information; and death records.

1 The Illinois Department shall enter into agreements with
2 State agencies and departments, and is authorized to enter into
3 agreements with federal agencies and departments, under which
4 such agencies and departments shall share data necessary for
5 medical assistance program integrity functions and oversight.
6 The Illinois Department shall develop, in cooperation with
7 other State departments and agencies, and in compliance with
8 applicable federal laws and regulations, appropriate and
9 effective methods to share such data. At a minimum, and to the
10 extent necessary to provide data sharing, the Illinois
11 Department shall enter into agreements with State agencies and
12 departments, and is authorized to enter into agreements with
13 federal agencies and departments, including but not limited to:
14 the Secretary of State; the Department of Revenue; the
15 Department of Public Health; the Department of Human Services;
16 and the Department of Financial and Professional Regulation.

17 Beginning in fiscal year 2013, the Illinois Department
18 shall set forth a request for information to identify the
19 benefits of a pre-payment, post-adjudication, and post-edit
20 claims system with the goals of streamlining claims processing
21 and provider reimbursement, reducing the number of pending or
22 rejected claims, and helping to ensure a more transparent
23 adjudication process through the utilization of: (i) provider
24 data verification and provider screening technology; and (ii)
25 clinical code editing; and (iii) pre-pay, pre- or
26 post-adjudicated predictive modeling with an integrated case

1 management system with link analysis. Such a request for
2 information shall not be considered as a request for proposal
3 or as an obligation on the part of the Illinois Department to
4 take any action or acquire any products or services.

5 The Illinois Department shall establish policies,
6 procedures, standards and criteria by rule for the acquisition,
7 repair and replacement of orthotic and prosthetic devices and
8 durable medical equipment. Such rules shall provide, but not be
9 limited to, the following services: (1) immediate repair or
10 replacement of such devices by recipients; and (2) rental,
11 lease, purchase or lease-purchase of durable medical equipment
12 in a cost-effective manner, taking into consideration the
13 recipient's medical prognosis, the extent of the recipient's
14 needs, and the requirements and costs for maintaining such
15 equipment. Subject to prior approval, such rules shall enable a
16 recipient to temporarily acquire and use alternative or
17 substitute devices or equipment pending repairs or
18 replacements of any device or equipment previously authorized
19 for such recipient by the Department. Notwithstanding any
20 provision of Section 5-5f to the contrary, the Department may,
21 by rule, exempt certain replacement wheelchair parts from prior
22 approval and, for wheelchairs, wheelchair parts, wheelchair
23 accessories, and related seating and positioning items,
24 determine the wholesale price by methods other than actual
25 acquisition costs.

26 The Department shall require, by rule, all providers of

1 durable medical equipment to be accredited by an accreditation
2 organization approved by the federal Centers for Medicare and
3 Medicaid Services and recognized by the Department in order to
4 bill the Department for providing durable medical equipment to
5 recipients. No later than 15 months after the effective date of
6 the rule adopted pursuant to this paragraph, all providers must
7 meet the accreditation requirement.

8 The Department shall execute, relative to the nursing home
9 prescreening project, written inter-agency agreements with the
10 Department of Human Services and the Department on Aging, to
11 effect the following: (i) intake procedures and common
12 eligibility criteria for those persons who are receiving
13 non-institutional services; and (ii) the establishment and
14 development of non-institutional services in areas of the State
15 where they are not currently available or are undeveloped; and
16 (iii) notwithstanding any other provision of law, subject to
17 federal approval, on and after July 1, 2012, an increase in the
18 determination of need (DON) scores from 29 to 37 for applicants
19 for institutional and home and community-based long term care;
20 if and only if federal approval is not granted, the Department
21 may, in conjunction with other affected agencies, implement
22 utilization controls or changes in benefit packages to
23 effectuate a similar savings amount for this population; and
24 (iv) no later than July 1, 2013, minimum level of care
25 eligibility criteria for institutional and home and
26 community-based long term care; and (v) no later than October

1 1, 2013, establish procedures to permit long term care
2 providers access to eligibility scores for individuals with an
3 admission date who are seeking or receiving services from the
4 long term care provider. In order to select the minimum level
5 of care eligibility criteria, the Governor shall establish a
6 workgroup that includes affected agency representatives and
7 stakeholders representing the institutional and home and
8 community-based long term care interests. This Section shall
9 not restrict the Department from implementing lower level of
10 care eligibility criteria for community-based services in
11 circumstances where federal approval has been granted.

12 The Illinois Department shall develop and operate, in
13 cooperation with other State Departments and agencies and in
14 compliance with applicable federal laws and regulations,
15 appropriate and effective systems of health care evaluation and
16 programs for monitoring of utilization of health care services
17 and facilities, as it affects persons eligible for medical
18 assistance under this Code.

19 The Illinois Department shall report annually to the
20 General Assembly, no later than the second Friday in April of
21 1979 and each year thereafter, in regard to:

22 (a) actual statistics and trends in utilization of
23 medical services by public aid recipients;

24 (b) actual statistics and trends in the provision of
25 the various medical services by medical vendors;

26 (c) current rate structures and proposed changes in

1 those rate structures for the various medical vendors; and
2 (d) efforts at utilization review and control by the
3 Illinois Department.

4 The period covered by each report shall be the 3 years
5 ending on the June 30 prior to the report. The report shall
6 include suggested legislation for consideration by the General
7 Assembly. The filing of one copy of the report with the
8 Speaker, one copy with the Minority Leader and one copy with
9 the Clerk of the House of Representatives, one copy with the
10 President, one copy with the Minority Leader and one copy with
11 the Secretary of the Senate, one copy with the Legislative
12 Research Unit, and such additional copies with the State
13 Government Report Distribution Center for the General Assembly
14 as is required under paragraph (t) of Section 7 of the State
15 Library Act shall be deemed sufficient to comply with this
16 Section.

17 Rulemaking authority to implement Public Act 95-1045, if
18 any, is conditioned on the rules being adopted in accordance
19 with all provisions of the Illinois Administrative Procedure
20 Act and all rules and procedures of the Joint Committee on
21 Administrative Rules; any purported rule not so adopted, for
22 whatever reason, is unauthorized.

23 On and after July 1, 2012, the Department shall reduce any
24 rate of reimbursement for services or other payments or alter
25 any methodologies authorized by this Code to reduce any rate of
26 reimbursement for services or other payments in accordance with

1 Section 5-5e.

2 Because kidney transplantation can be an appropriate, cost
3 effective alternative to renal dialysis when medically
4 necessary and notwithstanding the provisions of Section 1-11 of
5 this Code, beginning October 1, 2014, the Department shall
6 cover kidney transplantation for noncitizens with end-stage
7 renal disease who are not eligible for comprehensive medical
8 benefits, who meet the residency requirements of Section 5-3 of
9 this Code, and who would otherwise meet the financial
10 requirements of the appropriate class of eligible persons under
11 Section 5-2 of this Code. To qualify for coverage of kidney
12 transplantation, such person must be receiving emergency renal
13 dialysis services covered by the Department. Providers under
14 this Section shall be prior approved and certified by the
15 Department to perform kidney transplantation and the services
16 under this Section shall be limited to services associated with
17 kidney transplantation.

18 Notwithstanding any other provision of this Code to the
19 contrary, on or after July 1, 2015, all FDA approved forms of
20 medication assisted treatment prescribed for the treatment of
21 alcohol dependence or treatment of opioid dependence shall be
22 covered under both fee for service and managed care medical
23 assistance programs for persons who are otherwise eligible for
24 medical assistance under this Article and shall not be subject
25 to any (1) utilization control, other than those established
26 under the American Society of Addiction Medicine patient

1 placement criteria, (2) prior authorization mandate, or (3)
2 lifetime restriction limit mandate.

3 On or after July 1, 2015, opioid antagonists prescribed for
4 the treatment of an opioid overdose, including the medication
5 product, administration devices, and any pharmacy fees related
6 to the dispensing and administration of the opioid antagonist,
7 shall be covered under the medical assistance program for
8 persons who are otherwise eligible for medical assistance under
9 this Article. As used in this Section, "opioid antagonist"
10 means a drug that binds to opioid receptors and blocks or
11 inhibits the effect of opioids acting on those receptors,
12 including, but not limited to, naloxone hydrochloride or any
13 other similarly acting drug approved by the U.S. Food and Drug
14 Administration.

15 Upon federal approval, the Department shall provide
16 coverage and reimbursement for all drugs that are approved for
17 marketing by the federal Food and Drug Administration and that
18 are recommended by the federal Public Health Service or the
19 United States Centers for Disease Control and Prevention for
20 pre-exposure prophylaxis and related pre-exposure prophylaxis
21 services, including, but not limited to, HIV and sexually
22 transmitted infection screening, treatment for sexually
23 transmitted infections, medical monitoring, assorted labs, and
24 counseling to reduce the likelihood of HIV infection among
25 individuals who are not infected with HIV but who are at high
26 risk of HIV infection.

1 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;
2 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.
3 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,
4 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;
5 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-407 (see Section
6 20 of P.A. 99-588 for the effective date of P.A. 99-407);
7 99-433, eff. 8-21-15; 99-480, eff. 9-9-15; 99-588, eff.
8 7-20-16; 99-642, eff. 7-28-16; 99-772, eff. 1-1-17; 99-895,
9 eff. 1-1-17; 100-538, eff. 1-1-18.)

10 (305 ILCS 5/5-8) (from Ch. 23, par. 5-8)

11 (Text of Section before amendment by P.A. 100-538)

12 Sec. 5-8. Practitioners. In supplying medical assistance,
13 the Illinois Department may provide for the legally authorized
14 services of (i) persons licensed under the Medical Practice Act
15 of 1987, as amended, except as hereafter in this Section
16 stated, whether under a general or limited license, (ii)
17 persons licensed under the Nurse Practice Act as advanced
18 practice nurses, regardless of whether or not the persons have
19 written collaborative agreements, (iii) persons licensed or
20 registered under other laws of this State to provide dental,
21 medical, pharmaceutical, optometric, podiatric, or nursing
22 services, or other remedial care recognized under State law,
23 and (iv) persons licensed under other laws of this State as a
24 clinical social worker. The Department shall adopt rules, no
25 later than 90 days after the effective date of this amendatory

1 Act of the 99th General Assembly, for the legally authorized
2 services of persons licensed under other laws of this State as
3 a clinical social worker. The Department may not provide for
4 legally authorized services of any physician who has been
5 convicted of having performed an abortion procedure in a wilful
6 and wanton manner on a woman who was not pregnant at the time
7 such abortion procedure was performed. The utilization of the
8 services of persons engaged in the treatment or care of the
9 sick, which persons are not required to be licensed or
10 registered under the laws of this State, is not prohibited by
11 this Section.

12 (Source: P.A. 99-173, eff. 7-29-15; 99-621, eff. 1-1-17.)

13 (Text of Section after amendment by P.A. 100-538)

14 Sec. 5-8. Practitioners. In supplying medical assistance,
15 the Illinois Department may provide for the legally authorized
16 services of (i) persons licensed under the Medical Practice Act
17 of 1987, as amended, except as hereafter in this Section
18 stated, whether under a general or limited license, (ii)
19 persons licensed under the Nurse Practice Act as advanced
20 practice nurses, regardless of whether or not the persons have
21 written collaborative agreements, (iii) persons licensed or
22 registered under other laws of this State to provide dental,
23 medical, pharmaceutical, optometric, podiatric, or nursing
24 services, or other remedial care recognized under State law,
25 and (iv) persons licensed under other laws of this State as a

1 clinical social worker. The Department shall adopt rules, no
2 later than 90 days after the effective date of this amendatory
3 Act of the 99th General Assembly, for the legally authorized
4 services of persons licensed under other laws of this State as
5 a clinical social worker. The Department may not provide for
6 legally authorized services of any physician who has been
7 convicted of having performed an abortion procedure in a
8 willful and wanton manner on a woman who was not pregnant at
9 the time such abortion procedure was performed. The utilization
10 of the services of persons engaged in the treatment or care of
11 the sick, which persons are not required to be licensed or
12 registered under the laws of this State, is not prohibited by
13 this Section.

14 (Source: P.A. 99-173, eff. 7-29-15; 99-621, eff. 1-1-17;
15 100-538, eff. 1-1-18.)

16 (305 ILCS 5/5-9) (from Ch. 23, par. 5-9)

17 (Text of Section before amendment by P.A. 100-538)

18 Sec. 5-9. Choice of medical dispensers. Applicants and
19 recipients shall be entitled to free choice of those qualified
20 practitioners, hospitals, nursing homes, and other dispensers
21 of medical services meeting the requirements and complying with
22 the rules and regulations of the Illinois Department. However,
23 the Director of Healthcare and Family Services may, after
24 providing reasonable notice and opportunity for hearing, deny,
25 suspend or terminate any otherwise qualified person, firm,

1 corporation, association, agency, institution, or other legal
2 entity, from participation as a vendor of goods or services
3 under the medical assistance program authorized by this Article
4 if the Director finds such vendor of medical services in
5 violation of this Act or the policy or rules and regulations
6 issued pursuant to this Act. Any physician who has been
7 convicted of performing an abortion procedure in a wilful and
8 wanton manner upon a woman who was not pregnant at the time
9 such abortion procedure was performed shall be automatically
10 removed from the list of physicians qualified to participate as
11 a vendor of medical services under the medical assistance
12 program authorized by this Article.

13 (Source: P.A. 95-331, eff. 8-21-07.)

14 (Text of Section after amendment by P.A. 100-538)

15 Sec. 5-9. Choice of medical dispensers. Applicants and
16 recipients shall be entitled to free choice of those qualified
17 practitioners, hospitals, nursing homes, and other dispensers
18 of medical services meeting the requirements and complying with
19 the rules and regulations of the Illinois Department. However,
20 the Director of Healthcare and Family Services may, after
21 providing reasonable notice and opportunity for hearing, deny,
22 suspend or terminate any otherwise qualified person, firm,
23 corporation, association, agency, institution, or other legal
24 entity, from participation as a vendor of goods or services
25 under the medical assistance program authorized by this Article

1 if the Director finds such vendor of medical services in
2 violation of this Act or the policy or rules and regulations
3 issued pursuant to this Act. Any physician who has been
4 convicted of performing an abortion procedure in a willful and
5 wanton manner upon a woman who was not pregnant at the time
6 such abortion procedure was performed shall be automatically
7 removed from the list of physicians qualified to participate as
8 a vendor of medical services under the medical assistance
9 program authorized by this Article.

10 (Source: P.A. 100-538, eff. 1-1-18.)

11 (305 ILCS 5/6-1) (from Ch. 23, par. 6-1)

12 (Text of Section before amendment by P.A. 100-538)

13 Sec. 6-1. Eligibility requirements. Financial aid in
14 meeting basic maintenance requirements shall be given under
15 this Article to or in behalf of persons who meet the
16 eligibility conditions of Sections 6-1.1 through 6-1.10. In
17 addition, each unit of local government subject to this Article
18 shall provide persons receiving financial aid in meeting basic
19 maintenance requirements with financial aid for either (a)
20 necessary treatment, care, and supplies required because of
21 illness or disability, or (b) acute medical treatment, care,
22 and supplies only. If a local governmental unit elects to
23 provide financial aid for acute medical treatment, care, and
24 supplies only, the general types of acute medical treatment,
25 care, and supplies for which financial aid is provided shall be

1 specified in the general assistance rules of the local
2 governmental unit, which rules shall provide that financial aid
3 is provided, at a minimum, for acute medical treatment, care,
4 or supplies necessitated by a medical condition for which prior
5 approval or authorization of medical treatment, care, or
6 supplies is not required by the general assistance rules of the
7 Illinois Department. Nothing in this Article shall be construed
8 to permit the granting of financial aid where the purpose of
9 such aid is to obtain an abortion, induced miscarriage or
10 induced premature birth unless, in the opinion of a physician,
11 such procedures are necessary for the preservation of the life
12 of the woman seeking such treatment, or except an induced
13 premature birth intended to produce a live viable child and
14 such procedure is necessary for the health of the mother or her
15 unborn child.

16 (Source: P.A. 92-111, eff. 1-1-02.)

17 (Text of Section after amendment by P.A. 100-538)

18 Sec. 6-1. Eligibility requirements. Financial aid in
19 meeting basic maintenance requirements shall be given under
20 this Article to or in behalf of persons who meet the
21 eligibility conditions of Sections 6-1.1 through 6-1.10,
22 except as provided in the No Taxpayer Funding for Abortion Act.

23 In addition, each unit of local government subject to this
24 Article shall provide persons receiving financial aid in
25 meeting basic maintenance requirements with financial aid for

1 either (a) necessary treatment, care, and supplies required
2 because of illness or disability, or (b) acute medical
3 treatment, care, and supplies only. If a local governmental
4 unit elects to provide financial aid for acute medical
5 treatment, care, and supplies only, the general types of acute
6 medical treatment, care, and supplies for which financial aid
7 is provided shall be specified in the general assistance rules
8 of the local governmental unit, which rules shall provide that
9 financial aid is provided, at a minimum, for acute medical
10 treatment, care, or supplies necessitated by a medical
11 condition for which prior approval or authorization of medical
12 treatment, care, or supplies is not required by the general
13 assistance rules of the Illinois Department.

14 (Source: P.A. 100-538, eff. 1-1-18.)

15 Section 910. The Problem Pregnancy Health Services and Care
16 Act is amended by changing Section 4-100 as follows:

17 (410 ILCS 230/4-100) (from Ch. 111 1/2, par. 4604-100)

18 (Text of Section before amendment by P.A. 100-538)

19 Sec. 4-100. The Department may make grants to nonprofit
20 agencies and organizations which do not use such grants to
21 refer or counsel for, or perform, abortions and which
22 coordinate and establish linkages among services that will
23 further the purposes of this Act and, where appropriate, will
24 provide, supplement, or improve the quality of such services.

1 (Source: P.A. 83-51.)

2 (Text of Section after amendment by P.A. 100-538)

3 Sec. 4-100. The Department may make grants to nonprofit
4 agencies and organizations which do not use such grants to
5 refer or counsel for, or perform, abortions and which
6 coordinate and establish linkages among services that will
7 further the purposes of this Act and, where appropriate, will
8 provide, supplement, or improve the quality of such services.

9 (Source: P.A. 100-538, eff. 1-1-18.)

10 Section 990. Application of Act; home rule powers.

11 (a) This Act applies to all State and local (including home
12 rule unit) laws, ordinances, policies, procedures, practices,
13 and governmental actions and their implementation, whether
14 statutory or otherwise and whether adopted before or after the
15 effective date of this Act.

16 (b) A home rule unit may not adopt any rule in a manner
17 inconsistent with this Act. This Act is a limitation under
18 subsection (i) of Section 6 of Article VII of the Illinois
19 Constitution on the concurrent exercise by home rule units of
20 powers and functions exercised by the State.

21 Section 995. No acceleration or delay. Where this Act makes
22 changes in a statute that is represented in this Act by text
23 that is not yet or no longer in effect (for example, a Section

1 represented by multiple versions), the use of that text does
2 not accelerate or delay the taking effect of (i) the changes
3 made by this Act or (ii) provisions derived from any other
4 Public Act.

5 Section 999. Effective date. This Act takes effect on the
6 earlier of the effective date of Public Act 100-538 or June 1,
7 2018.

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INDEX

Statutes amended in order of appearance

New Act

- 5 ILCS 375/6 from Ch. 127, par. 526
- 5 ILCS 375/6.1 from Ch. 127, par. 526.1
- 305 ILCS 5/5-5 from Ch. 23, par. 5-5
- 305 ILCS 5/5-8 from Ch. 23, par. 5-8
- 305 ILCS 5/5-9 from Ch. 23, par. 5-9
- 305 ILCS 5/6-1 from Ch. 23, par. 6-1
- 410 ILCS 230/4-100 from Ch. 111 1/2, par. 4604-100